# GIC Medicare Enrolled Retirees

***Effective 7/1/2016***

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**HMO Summary of Benefits Chart**

This chart provides a summary of key services offered by your Health New England plan. Consult your Member Handbook for a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your Member Handbook, the terms of the Member Handbook apply.

| BENEFIT | Copay |
|---|---|
| **Inpatient Care** | |
| Acute Hospital Care | $0 |
| Inpatient Rehabilitation | $0 |
| Skilled Care Facility *(maximum of 100 days per Policy Year)* | $0 |
| **Outpatient Preventive Care** | |
| Adult Routine Physical Exams by your PCP | $0 |
| Pediatric Preventive Care | $0 |
| Annual Gynecological Exam | $0 |
| Screening Mammographic Exam | $0 |
| Medically Necessary Adult and Child Immunizations by your PCP | $0 |
| Nutritional Counseling *(maximum of four visits per Policy Year)* | $0 |
| **Other Outpatient Care** | |
| PCP Office Visits | $10/visit |
| Specialist Office Visits | $10/visit |
| Second Opinions | $10/visit |
| Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc™ | $10/consultation |
| Routine Eye Exam *(one per Policy Year)* | $10/visit |
| Hearing Tests in your PCP's office | $10/visit |
| Diabetic-Related Items | |
| Outpatient Services | $10/visit |
| Laboratory/Radiological Services | $0 |
| Durable Medical Equipment *(diabetic-related; some items require Prior Approval)* | $0 |
| Group Diabetic Education | $10/session |
| Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder | $0 |
| Emergency Room Care *(Copay waived if admitted directly from ER)* | $50/visit |

| BENEFIT | Copay |
|---|---|
| Diagnostic Testing | |
| In a Doctor's Office | $10/visit |
| In All Other Settings | $0 |
| Laboratory Services | $0 |
| Radiological Services: Ultrasound, X-rays, Nuclear Cardiology (*Nuclear Cardiac Imaging requires Prior Approval*) | $0 |
| Advanced Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans *(requires Prior Approval)* | $0 |
| Outpatient Short-Term Rehabilitation Services *(Covered for 90 days per acute episode, per Policy Year. The limit does not apply when services are provided to treat Autism Spectrum Disorder.)* | $10/visit/treatment type |
| Day Rehabilitation Program *(limited to 15 full day or half day sessions per condition per lifetime)* | $25/day or half day |
| Early Intervention Services *(covered for children from birth to age 3)* | $0 |
| Outpatient Surgical Services and Procedures *(some services require Prior Approval)* | |
| In a Doctor's Office | $10/visit |
| All Other Settings | $0 |
| Allergy Testing and Treatment in an Allergist's Office | $10/visit; $0 for injection |
| **Infertility Services** *(some infertility treatments require Prior Approval)* | |
| Outpatient Care | $10/visit |
| Laboratory Tests | $0 |
| Inpatient Care | $0 |
| **Maternity Care** | |
| Routine Prenatal and Postpartum Care | $0 |
| Delivery/Hospital Care for Mother and Child *(Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)* | $0 |
| **Dental Services** | |
| Surgical Treatment of Non-Dental Conditions *(requires Prior Approval)* and Emergency Dental Care | |
| In a Doctor's Office | $10/visit |
| At an Emergency Room | $50/visit |
| Hospital Inpatient | $0 |
| Outpatient Surgical Facility | $0 |

| BENEFIT | Copay |
|---|---|
| **Other Services** | |
| Home Health Care *(requires Prior Approval)* | $0 |
| Hospice Services *(requires Prior Approval)* | $0 |
| Durable Medical Equipment and Prosthetic Equipment<br>*(some items require Prior Approval)* | 20% Coinsurance |
| Scalp Hair Prostheses (Wigs) for hair loss due to treatment of any form of cancer or leukemia *(Health New England covers one prosthesis per Policy Year)* | $0 |
| Ambulance and Chair Van Services<br>*(non-emergency transportation requires Prior Approval)* | $25/member/day |
| Reconstructive or Restorative Surgery | $0 |
| Kidney Dialysis | $0 |
| Human Organ Transplants and Bone Marrow Transplants<br>*(requires Prior Approval)* | $0 |
| Nutritional Support *(requires Prior Approval)* | $0 |
| Cardiac Rehabilitation | $10/visit |
| Speech, Hearing, and Language Disorders<br>*(requires Prior Approval after the initial evaluation)* | $10/visit |
| Coronary Artery Disease Program<br>*(Provided for members with documented coronary artery disease, this program helps participants reduce coronary artery disease risk factors through lifestyle changes. The program must be authorized by your PCP.)* | 10% Coinsurance |
| Hearing aids | |
| • • Members 21 and under<br>*(Health New England covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid. Prior Approval is required.)* | 100% coverage up to $2,000 per device per ear (you are responsible for all costs beyond maximum) |
| • • Members over 21 years old<br>*(Health New England reimburses for hearing aids at 100% for the first $500 and 80% for the next $1,500 per person, up to a maximum of $1,700, every two Policy Years.)* | 100% coverage for the first $500 and 80% for the next $1,500 per person, every two Policy Years |
| **Behavioral Health Services (Mental Health and Substance Abuse)**<br>*(Some services may require Prior Approval)* | |
| Inpatient Services | $0 |
| Intermediate Services *(such as Partial Hospitalization)* | $0 |
| Outpatient Services | $10/visit |

# PRESCRIPTION DRUG COVERAGE

| **Prescription Drugs** *(certain drugs require Prior Approval)*<br>Your Prescription Drug benefit covers those items described in the Health New England Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Health New England Formulary. | **Copay** |
|---|---|
| **At a Plan Pharmacy (up to a 30-day supply):** | |
| Generic Drugs | $10 |
| Formulary Drugs | $30 |
| Non-formulary Drugs | $65 |
| **Through Mail Order (a 90-day supply of maintenance medication):** | |
| Generic drugs | $25 |
| Formulary drugs | $75 |
| Non-formulary drugs | $165 |
| **At a Pharmacy Participating in the Access 90 Program (a 90-day supply of maintenance medication):** | |
| Generic Drugs | $30 |
| Formulary Drugs | $90 |
| Non-formulary Drugs | $195 |